acute closure, slow or no flow, acute stent thrombosis in any pt. So, also no puncture site or non-puncture site major or minor bleeds.
Conclusion: Bivalirudin seems to improve TIMI frame counts before angioplasty. Further studies are required to confirm and to postulate the mechanism of improvement of TIMI frame counts.

Antegrade corsair usage in mild/moderate calcific coronary chronic total occlusions

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Background: As a supporting catheter in CTO PCI, Fine cross micro-catheter is preferred for Antegrade and Corsair micro-catheter for Retrograde route. Corsair may malfunction in calcific coronary lesions.
Aim: As the Corsair has tapered tip and good tractability in tortuous vessels we want to see the efficiency and safety of Corsair in mid/moderately calcific Antegrade second attempt CTO PCI.
Methods: We did retrospective analysis of 15 mild/moderately calcific, symptomatic patients Antegrade CTO PCI details (second attempt) in whom corsair is used. Coronary calcification was detected by flat panel digital detector fluoroscopic system (FPDD).
Results: Out of 15 patients, 12 were males, with mean age of 59.7 yrs and historically CTO duration was varying from 1 to 11 yrs. Total no of lesions treated were 22 in 15 pts, 15 CTOs and 7 other vessel lesions and majority of lesions were in RCA 7 (46.7%). Average amount of contrast, fluoroscopic and procedural times were 146±20ml, 33.6±10.2 minutes and 63.2±30.9 minutes respectively. Unfavourable CTO lesion like moderate calcium in 10 (66.7%) lesions, significant proximal vessel tortuosity in 5 (33.3%) lesions, diffuse proximal disease in 3(20%), bent at occlusion in 4 (26.7%), bridging collaterals at occlusion in 3 (20%) and side branch at occlusion were present in 9 (60%) lesions. None of cases showed any distortion or fracture or entrapment of the Corsair. In hospital complication rate due to contrast nephropathy (one patient) and MACCE at 9 months due to TVR (one patient) was 6.6%.
Conclusion: Corsair micro catheter is useful in crossing the mild/moderate complex selected calcific Antegrade CTO PCI with low in hospital complications.

Direct culprit vessel primary PCI to LAD followed by contra lateral angiography by transradial route in acute myocardial infarction – Direct Study

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Background: Percutaneous coronary intervention (PCI) of the infarct related artery (IRA) during primary PCI for ST elevation myocardial infarction (STEMI) is appropriate. Two retrospective analyses suggested that, direct PCI to the IRA without knowledge of the anatomy of the contra lateral artery is feasible .This approach would shorten the door to balloon time which is a validated surrogate for mortality in AMI. We have reported the feasibility in a pilot study (Direct prospective Pilot study). In the presentstudy we tested the hypothesis that in anterior STEMI, direct PCI to left anterior descending (LAD) artery before right coronary artery angiography is feasible and this would shorten the door to balloon (d2b) time.
Methods: Anterior wall STEMI was diagnosed by standard criteria. All consecutive patients of anterior MI admitted between March 2012 and April 2014 were studied prospectively. Patients with cardiogenic shock were excluded. Patients were treated with aspirin 150 to 325 mg, ticagrelor 180 mg and atorvastatin 80 mg and shifted to cath lab. Radial access was obtained by anterior wall puncture. LMCA was hooked with 6F XB guiding catheter and primary PCI to LAD was done as per standard protocol. After successful PCI to LAD, the RCA angiogram was performed with a 5 F TF catheter. All the intervals were recorded.
Results: 41 patients of anterior MI were treated. 30 DES and 12 BVS were deployed. The median d2b time was 35+11.8 minutes and the mean d2b time was 36.46+14.3min. Prior RCA angiogram would have prolonged the median d2b time by 2.45 minutes (p=0.05) and mean d2b time by 4.76 minutes (p=<0.05).
Conclusion: From this multicenter study, we conclude that in anterior wall STEMI, it is feasible to perform PCI to LAD directly without knowing the RCA anatomy which significantly shortens the d2b time. Randomized controlled trial is warranted.

Factors determining stent length & outcomes

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Background: In the previous studies it was shown that longer the stent length more the chances of ISR .In the present study we aimed to identify whether the stent length and type of stent and risk factors determining the outcomes.
Methods: Retrospective analysis of 58 patients records who underwent PCI were included. Patients were grouped into stent length <15mm (G1) & Stent length(G2) >15mm. Analysis of various factors determing stent length and its out come were done using ANOVA test & regression analysis. Primary out comes were new leisons & In Stent Restenosis.
Results: Mean age of the study population was 55 years and female were11, among them hypertensive patients were 39, diabetics were 31, and smokers were 16. Out of 58, acute coronary syndromes (ACS) were 34 and total number of lesions was 76. PCI was done through the radial puncture in 23 patients. Culprit vessels were LAD in 29, LCX in 14, LMCA in 1, and rest RCA. Type of lesions included B1 in 1, B2 in 45 and C in 12. In G1- 14 & G2 -42, of which total events were 2 in G1 (P-0.14) & 11 in G2 (P-0.26). P value of the two p-(0.3) gives there is no difference when total events vs stent length (p=0.3).
G1 had 2 new lesions & no ISR, G2 had 6 new lesions & 5 had ISR, But significant difference in occurrence of ISR and stent length (p=0.02). BMS group -4 had new lesions & 1 ISR, & DES group-4 new lesions & 4 ISR. If we see the type of stent either DES or BMS there is no difference in occurrence of either ISR (p=0.5) or total events (0.34). General Regression Analysis: stent length versus age, Hemoglobin, PCV, DM etc showed DM (P-0.03), RBS(P-0.006), Type of CAD(p-0.021) suggest that length of the stent is more in DM, hyperglycemic pts and ACS patients.
Conclusions: Most important factors determining stent length are DM, new hyperglycemia and ACS status.